STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

Medical Use of Marijuana Program

Designation Form

(For patients to designate a caregiver or dispensary)

SECTION 1: Patient Information			
Legal Name:			
Date of Birth:	Driver's License No.:	Telephone No.: ( )	
Home Address:			
City:	State:	Zip:	County:
Expiration date of Provider Certification:			

SECTION 2: Cultivation Authorization **May only allocate up to 6 plants**

_____ # of plants I will grow

_____# of plants my caregiver will grow

_____# of plants my dispensary will grow

☐ Visiting qualifying patient (must be included as 1 of the 5 patients allowed per caregiver)

May Designate caregiver or dispensary-Not both **Total # (Not to exceed 6) _____**

SECTION 3: Medical Marijuana Transportation

How will the medical marijuana be transported? (Check all that apply)

☐ I will pick up the medical marijuana from my designated caregiver/dispensary.

☐ The designated caregiver/dispensary will deliver my medical marijuana to me.

☐ Name of designated caregiver. (See Caregiver information section 4)

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Maine Medical Use of Marijuana Program
41 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-4325 Fax: (207) 287-2671
Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: medmarijuana.dhhs@maine.gov
Website: http://www.maine.gov/dhhs/dlrs/mmm/index.shtml

SECTION 4: Caregiver Designation (Complete only if designating a Caregiver)			
Legal Name:			
Telephone No.: ( )			
Street Address:			
City:	State:	Zip:	County:
Caregiver MMMP Registration # assigned to this patient: (if cultivating for the patient and registration is required)			
Primary caregiver registration required; EXCEPTIONS, Section 5.4 ○ Section 5.4.1: A primary caregiver designated to cultivate for a qualifying patient if that qualifying patient Is a member of the household of that primary caregiver; ○ Section 5.4.2: Two primary caregivers who are also both qualifying patients, if those primary caregivers are members of the same household and assist one another with cultivation; ○ Section 5.4.3: A primary caregiver who cultivates for a qualifying patient if that qualifying patient is a member of the family of that primary caregiver (see 22MRSA 2423-A (3) (C)			

SECTION 5: Dispensary Designation (Complete only if designating a Dispensary)	
Name of Dispensary:	
City:	Telephone No.: ( )
Name of Dispensary Representative:	
Name of Non Grow Caregiver, if any, who may pick up marijuana for me at the dispensary:	

SECTION 6: Expiration and Renewal of Designation

Expiration:

This designation form expires on (month/day/year) _____.

Renewal:

The patient is required to complete a new designation form annually in order to renew the designation of a caregiver or dispensary.

SECTION 7: Patient Rights and Responsibilities

- My provider has certified that I have a condition that entitles me to participate in the Maine Medical Use of Marijuana Program until _____. I have provided you with either a copy of that certification or a copy of my Maine Medical Use of Marijuana Program identification card as proof that I am authorized to participate in the program. I have also provided you a copy of my Maine issued driver license or other Maine issued photo identification card as proof of my identity.
- If I am visiting from another state, I have provided you with a copy of the MMMP provider certification form completed by my provider in the state of _____ as evidence that I live in a state that authorizes marijuana for medical purposes and have a debilitating condition authorized under Maine law. I have also provided you with a copy of my photographic identification card or driver's license from my home jurisdiction. As a visiting qualifying patient, I agree to abide by all terms and conditions of the Maine Medical Use of Marijuana Program.

You are hereby authorized to share this caregiver designation form and any copies of documents that I am required to provide to a member of the law enforcement community in order to verify the services you are providing to me are authorized under Maine law.

I have the right to terminate this agreement at any time. This caregiver designation form is my property, and any authorized activity conveyed to you through this designation form terminates upon my notice. You must either dispose of the excess marijuana in your possession on my behalf, or replace me with another qualified patient. You will have 10 days from the date of notice to return this form to me.

In the event I terminate this agreement and you do not return this designation form to me, I authorize the Maine Department of Health and Human Services to demand the return of this designation form or take other action to enforce the Rules Governing the Maine Medical Use of Marijuana Program, which includes terminating the caregiver number that they assigned to you and that you have listed on this designation form.

_____	_____	_____
Print name of patient/guardian	**Signature of patient/guardian**	**Date**
_____	_____	_____
Print name of caregiver	**Signature of caregiver**	**Date**
_____	_____	_____
Print name of dispensary representative	**Signature of dispensary representative**	**Date**